III. Hospital Outpatient Prospective Payment System (PPS)

In this section, we designate the services for which Medicare will make payment under the hospital outpatient PPS, the payment rates set for those services, and the method by which we determined the outpatient PPS payment and coinsurance amounts.

We explain the structure of the hospital outpatient PPS, respond to comments that we received about the proposed PPS, and describe modifications that we made to the proposed PPS in response to comments, such as provisions we are making to expedite appropriate payment for new technologies and provisions to pay for blood and blood products.

In this section, we also discuss how we will implement requirements enacted by the BBRA 1999, including transitional payment corridors and other payment adjustments such as outliers and transitional pass-throughs.

A. Hospitals Included In or Excluded From the Outpatient PPS

This PPS applies to covered hospital outpatient services furnished by all hospitals participating in the Medicare program, except as noted below. Partial hospitalization services in community mental health centers

(CMHCs) are also paid under this PPS. Exclusions from outpatient PPS are different and more limited than exclusions from inpatient PPS. Thus, hospitals or distinct parts of hospitals that are excluded from the inpatient PPS are included in the outpatient PPS, to the extent that the hospital or distinct part furnishes outpatient services. For example, we will make payment under the outpatient PPS for outpatient psychiatric services. The outpatient services provided by hospitals of the Indian Health Service (IHS) will continue to be paid under separately established rates which are published annually in the **Federal Register**. We intend to develop a plan that will help these facilities transition to the PPS and will consult with the IHS to develop this plan.

The following hospitals are excluded from the outpatient PPS:

! Certain hospitals in Maryland qualify under section 1814(b)(3) of the Act for payment under the State's payment system. The excluded services are limited to those paid under the State's payment system as described in section 1814(b)(3) of the Act. Any other outpatient

services furnished by the hospital are paid under the outpatient PPS.

! Critical access hospitals that are paid under a reasonable cost based system, as required under section 1834(g) of the Act.

Comment: National and State associations representing children's hospitals and a number of individual children's hospitals located across the country strongly recommended that their hospitals be excluded from the hospital outpatient PPS just as they have been excluded from the hospital inpatient PPS. These commenters argued that the exclusion should apply to outpatient services furnished by children's hospitals because these hospitals treat a unique patient group whose health needs are different from those of adult beneficiaries entitled to Medicare benefits. The commenters further argued that services to Medicare patients are, on average, only 1 percent of the total inpatient and outpatient services that children's hospitals furnish and that these services are largely ESRD services that are already excluded from the hospital outpatient PPS. The commenters were concerned that the resources required to implement and comply with the new system would be

disproportionately high relative to the small number of patients who would be affected by the new system. In addition, the impact analysis that accompanied the proposed rule estimated that children’s hospitals would lose more than 20 percent of their Medicare revenues under the new system. Commenters expressed great concern about this loss of revenue.

Response: Our most recent analysis of the impact on hospitals of the PPS shows a negative effect for children's hospitals of 11.9 percent, which is significantly less than what we estimated in the proposed rule. However, the transitional corridor payments provided by the BBRA 1999 will protect these hospitals from even this level of loss through 2004. The estimated loss for CY 2000-2001 for children's hospitals is only 3.2 percent. (See Table 2 in section IX of this preamble.) As we discuss in section III.H.2 below, we will conduct extensive analyses during the first years of implementation of the PPS to determine whether we should propose adjustments for certain types of hospitals, including children's hospitals, when the transitional corridor provision expires. In the meantime,

we are not excluding any special class of hospital from the PPS.

B. Scope of Facility Services

Section 1833(t)(1)(B)(i) of the Act gives us the authority to designate the services to be covered under the hospital outpatient PPS. In this section of the final rule, we designate the types of services included or excluded under the hospital outpatient PPS.

1. Services Excluded from the Scope of Services Paid Under the Hospital Outpatient PPS

a. Background

In developing a hospital outpatient PPS, we want to ensure that all services furnished in a hospital outpatient setting will be paid on a prospective basis. We have already been paying, in part, for some hospital outpatient services such as clinical diagnostic laboratory services, orthotics, and end-stage renal disease (ESRD) dialysis services based on fee schedules or other prospectively determined rates that also apply across other sites of ambulatory care. Rather than duplicate existing payment systems that are effectively achieving consistency of payments across different service delivery sites, we

proposed to exclude from the outpatient PPS those services furnished in a hospital outpatient setting that were already subject to an existing fee schedule or other prospectively determined payment rate. The similar payments across various settings create a more level playing field in which Medicare makes virtually the same payment for the same service, without regard to where the service is furnished.

We therefore proposed to exclude from the scope of services paid under the hospital outpatient PPS the following:

! Services already paid under fee schedules or other payment systems including, but not limited to: screening mammographies, services for patients with ESRD that are paid for under the ESRD composite rate; the professional services of physicians and non-physician practitioners paid under the Medicare physician fee schedule; laboratory services paid under the clinical diagnostic laboratory fee schedule; and DME, orthotics, prosthetics, and prosthetics devices, prosthetic implants, and supplies (DMEPOS) paid under the DMEPOS fee schedule when the hospital is acting as a supplier of these items. An item such as crutches or a walker that is given to the patient to take home, but that

may also be used while the patient is at the hospital, would be billed to the DME regional carrier rather than paid for under the hospital outpatient PPS.

- Hospital outpatient services furnished to SNF inpatients as part of his or her resident assessment or comprehensive care plan (and thus included under the SNF PPS) that are furnished by the hospital "under arrangements" but billable only by the SNF, regardless of whether or not the patient is in a Part A SNF stay.

- Services and procedures that require inpatient care.

The statute excludes from the definition of "covered OPD services" ambulance services, physical and occupational therapy, and speech-language pathology services, specified in section 1833(t)(1)(B)(iii) of the Act (redesignated as section 1833(t)(1)(B)(iv) by section 201(e) of the BBRA 1999). These services are to be paid under fee schedules in all settings.

b. Comments and Responses

Comment: One commenter urged that we exclude services furnished to ESRD patients from the scope of the hospital outpatient PPS.

Response: Services furnished to ESRD patients include dialysis, Epoietin (EPO), drugs, and supplies provided outside the composite rate, surgery specific to access grafts, and many other medical services related to renal disease or to other coexisting conditions. We will continue to base payment for dialysis services on the composite rate, and we will continue to pay for EPO based on the current rate established for that service. The drugs and supplies that are used within a dialysis session, but for which payment is not included in the composite rate, are paid outside that rate. We have to conduct further analyses in order to develop appropriate APC groups upon which to base payment. In the meantime, we will continue to pay on a reasonable cost basis for dialysis related drugs and supplies that are paid outside the composite rate.

Comment: A hospital industry association took exception to the requirement that hospitals obtain a separate supplier number, post a bond, and bill separately to the DME regional carrier for DME supplies such as crutches. They believe that this is an unnecessary requirement that results in additional costs for small rural hospitals. The commenter recommended that we include within

the PPS rate supplies such as crutches that are directly related to the provison of the hospital outpatient services or that we permit hospitals to bill under the DME fee schedule without having to obtain a DME supplier number or post a bond.

Response: Section 1834(j)(1)(A) of the Act provides that no payment may be made for items furnished by a supplier of medical equipment and supplies unless the supplier obtains a supplier number. Section 1834(a)(1)(C) of the Act provides that payment for DME can be made only under the DME fee schedule. Therefore, to receive payment for DME under Medicare, a hospital must obtain a supplier number and must meet the other requirements set by applicable Medicare rules and regulations.

Comment: Several major hospital associations and a number of other commenters opposed our proposal to exclude from payment certain procedures that we designate as "inpatient only." Other commenters, including a physician professional society, agree that many of the procedures that we designated in the proposed rule as "inpatient only" are currently performed appropriately and safely only in the inpatient setting. However, these commenters believe that

our explicit exclusion of individual procedures, besides being unnecessary, could have an adverse effect on advances in surgical care. Some commenters alleged that we provided no concrete support for designating procedures as "inpatient only." A number of commenters argued that medicine is not practiced uniformly across the nation and that some services listed among the exclusions are currently being performed on an outpatient basis in various parts of the country with positive outcomes.

An industry association stated that we failed to consider surgical judgment and patient choice in determining the appropriate treatment setting for certain services that we proposed to exclude from coverage. Other commenters believe that the appropriate site for performing a medical service is best determined by physicians and their patients. One professional society stated that case law including medical malpractice case law is sufficient to ensure that medical services are delivered in the appropriate treatment setting and in conformance with prevailing medical standards.

Response: We recognize and acknowledge that our assigning "inpatient only" status to certain services and

procedures raises numerous questions and concerns, and that some individual determinations can be reasonably debated. However, section 1833(t)(1)(B) of the Act explicitly authorizes the Secretary to designate which hospital outpatient services are to be "covered OPD services" subject to payment under the hospital outpatient PPS. Therefore, we have had to select from the universe of possible services those that we determine are reasonable, necessary, and appropriate for Medicare payment under the hospital outpatient PPS. We note that our designation of a service as "inpatient only" does not necessarily preclude the service from being furnished in a hospital outpatient setting, but means only that Medicare will not make payment for the service were it to be furnished to a Medicare beneficiary in that setting. This unfortunately leaves the beneficiary liable for payment if the procedure is in fact performed in the outpatient setting. We hope that hospitals will advise beneficiaries of the consequences if procedures on the inpatient list are provided as outpatient services (that is, denial of Medicare payment with concomitant beneficiary liability). In section III.C.5 of this preamble, we discuss in greater detail our rationale for

designating specific procedures as "inpatient only." In response to comments, we have removed the "inpatient only" status from a number of services, which will allow them to be paid under the hospital outpatient PPS. We emphasize our intention to review annually, in consultation with hospital and professional societies and associations and the expert outside advisory panel mandated by the BBRA 1999, those procedures classified as "inpatient only" to ensure that the designation remains consistent with current standards of practice.

Comment: One industry association contends that the statutory and regulatory authorities that we cite in the proposed rule (section 1862(a)(1)(A) of the Act and 42 CFR 411.15(k)(1), respectively) do not support the proposed medical services exclusions. The commenter argues that those provisions are the basis for prohibiting coverage for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. The commenter states that these provisions are not the basis upon which we identified services for the "inpatient only" list. The commenter further states that use of these provisions as a

basis for denying coverage of the services would be confusing to beneficiaries.

Response: The commenter is correct that the proper citations are not section 1862(a)(1) of the Act and 42 CFR 411.15(k)(1). In fact, the basis for our designating certain procedures as "inpatient only" is dependent on medical judgment regarding the proper site of service, and the proper citation for such designation is section 1833(t)(1)(B) of the Act. In some instances, the identification of services to be included or excluded from

this PPS was perfectly clear. For example, emergency departments (EDs) are outpatient departments of hospitals. Thus emergency services rendered in EDs qualify as outpatient services. On the other hand, coronary artery bypass graft surgery (CABG) requires many hours in surgery, part of the time with the patient's life being sustained by artificial means; a period of hours, if not days, in the surgical intensive care unit (ICU); and further care in an inpatient unit with frequent nursing attention. It clearly cannot be an outpatient procedure, and it would not be reasonable to consider it for inclusion in this PPS. There are many procedures which require similar intensity of care, including periods in specialty ICUs and several days of intense nursing attention.

Some procedures formerly performed only in the inpatient setting, however, have moved to the outpatient site of service. This movement has taken place due to new, less-invasive surgical techniques, such as laparoscopy, or new anesthesia agents that clear from the body more rapidly, allowing some patients to have general anesthesia in the morning and return home that afternoon. Thus we have had to decide which procedures may reasonably be performed in the

outpatient setting, and which cannot. We have been guided in this decision by our medical advisors' clinical judgment regarding what is reasonable in various settings, comments we received in response to the proposed rule, and bill data which shows movement from one site to another. In section III.C.5, we discuss the criteria we considered in defining "inpatient only" procedures.

Comment: One hospital asked how we would pay a hospital that routinely performs on an outpatient basis a procedure that we proposed to designate as "inpatient only." The commenter recommended that a specific billing mechanism be used to guarantee payment in these situations.

Response: Services designated as "inpatient only" will be excluded from Medicare payment under the hospital outpatient PPS. If the service is performed on an outpatient basis and a claim is submitted, the claim will be denied, and the beneficiary may be billed for the service. We would consider this a very poor policy on the hospital's part, and would hope that hospitals decide to abide by the constraints of the inpatient list.

Comment: One commenter noted that hospital outpatient departments have never been limited to a list of approved

procedures as are Medicare participating ASCs. The commenter stated that the "inpatient only" policy would exclude payment for a significant number of procedures that have traditionally been performed in the hospital outpatient setting. The commenter stated that some of the excluded procedures incorporate an observation stay in a recovery care center. The commenter contended that many of the excluded procedures could be safely performed in the outpatient setting particularly if a 24 to 72 hour recovery care center is part of the outpatient surgical care provided.

Response: Routinely billing an observation stay for patients recovering from outpatient surgery is not allowed under current Medicare rules nor will it be allowed under the hospital outpatient PPS. As we state in section III.C.5 of this preamble, one of the primary factors we considered as an indicator for the "inpatient only" designation is the need for at least 24 hours of postoperative care.

Comment: One commenter asked what option a hospital has if a beneficiary’s secondary insurer requires that a procedure included on the Medicare inpatient only list be performed on an outpatient basis.

Response: Upon implementation, the provisions of this final rule will govern payment for Medicare covered outpatient services furnished by hospitals to Medicare beneficiaries. Medicare payment policy and rules are not binding on employer-provided retiree coverage that may supplement Medicare coverage. Medigap insurers, however, must follow Medicare's coverage determinations.

c. Payment for Certain Implantable Items Under the BBRA 1999

In the course of identifying items and services whose costs we proposed to designate for payment under the hospital outpatient PPS, we gave considerable thought to including implantable items and services because these items and services are such an integral part of the procedure by which they are inserted or implanted. However, a number of the more common implants such as aqueous shunts, hallux valgus implants, infusion pumps, and neurostimulators, are classified as implantable prosthetics or DME. The statutory language governing payment for DMEPOS provides that, notwithstanding any other provision of the Medicare statute, DMEPOS must be paid for using the DMEPOS fee schedule. Therefore, under the proposed rule, the scope of services

paid under the hospital outpatient PPS did not include implantable prosthetics and DME paid under the DMEPOS fee schedule. However, we did propose to package payment for implanted items such as stents, vascular catheters, and venous ports within the APC payment rate for the procedure related to the insertion of these items because we define these items as supplies rather than as prosthetic implants or implantable DME.

Section 201(e) of the BBRA 1999 amends section 1833(t)(1)(B) of the Act to provide that "covered OPD services" include implantable items described in paragraph (3), (6), or (8) of section 1861(s) of the Act. The conference report accompanying the BBRA 1999, H. R. Rep. No. 436 (Part I), 106th Cong., 1st Sess. (1999), expresses the belief of the conferees that the current DMEPOS fee schedule is not appropriate for certain implantable medical items such as pacemakers, defibrillators, cardiac sensors, venous grafts, drug pumps, stents, neurostimulators, and orthopedic implants as well as items that come into contact with internal human tissue during invasive medical procedures, but are not permanently implanted. In the conference report agreement, the conferees state their

intention that payment for these items be made through the outpatient PPS, regardless of how these products might be classified on current HCFA fee schedules. The implantable items affected by this BBRA 1999 requirement include prosthetic implants (other than dental) that replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care and including replacement of these devices); implantable DME; and implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

Comment: A number of commenters disagreed with our proposal to pay under the DMEPOS fee schedule for implantable items and devices that require surgical insertion. We received comments on specific implantable items, including Vitrasert (a drug delivery system that is implanted in the eye); cochlear devices, which allow the profoundly deaf to hear sound and in some cases recognize speech; nerve stimulators that treat intractable epilepsy and other diseases; new technology intraocular lenses implanted following cataract surgery; and access devices for dialysis treatment. Commenters were also concerned that the costs of some implantable devices not paid under the DMEPOS

fee schedule, which we packaged in our proposed rule, were not properly recognized in the APC payment.

Response: As we explain above, the amendments made to the statute by section 201(e) of the BBRA 1999 provide for payment to be made under the hospital outpatient PPS for implantable items that are part of diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests; implantable durable medical equipment; and implantable prosthetic devices (other than dental). This BBRA 1999 provision requires that an implantable item be classified to the group that includes the service to which the item relates. Thus, under this final rule with comment period, we are including within the scope of the hospital outpatient PPS items such as aqueous shunts that would, absent the BBRA 1999 provision, have been paid under the DMEPOS fee schedule. Because implantable items are now packaged into the APC payment rate for the service or procedure with which they are associated, certain items may be candidates for the transitional pass-through payment, which is discussed in detail in section III.D of this preamble. The APC rates may not in every case perfectly recognize the cost of

implantable items. We will continue to review the impact of packaging implantables in future updates.

d. Summary of Final Action

We are modifying proposed §419.22 to remove prosthetic implants from the list of services excluded from payment under the hospital outpatient PPS. We are adding subparagraphs (9), (10), and (11) to proposed §419.2(b), to include the following in the list of items and services whose costs are included in hospital outpatient PPS payment rates: prosthetic implants (other than dental) that replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), and including replacement of these devices; implantable DME; and implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

2. Services Included Within the Scope of the Hospital Outpatient PPS

We proposed to include three categories of services within the scope of the outpatient PPS, as follows:

a. Services for Patients Who Have Exhausted Their Part A Benefits

Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the hospital outpatient PPS for certain services designated by the Secretary that are furnished to inpatients who have exhausted their Part A benefits or who are otherwise not in a covered Part A stay. Examples of services covered under this provision include diagnostic x-rays and certain other diagnostic services and radiation therapy covered under section 1832 of the Act.

b. Partial Hospitalization Services

Section 1833(a)(2)(B) of the Act provides that partial hospitalization services furnished in CMHCs be paid under the hospital outpatient PPS. Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients who have profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

c. Services Designated by the Secretary

We proposed to designate the following services to be paid under the hospital outpatient PPS:

- All hospital outpatient services, except those that are identified as excluded, above, in section III.B.1 of this

final rule. The types of services subject to payment under the hospital outpatient PPS include the following: surgical procedures; radiology, including radiation therapy; clinic visits; emergency department visits; diagnostic services and other diagnostic tests; partial hospitalization for the mentally ill; surgical pathology; and cancer chemotherapy.

! Specific hospital outpatient services furnished to a beneficiary who is admitted to a Medicare-participating SNF but who is not considered to be a SNF resident, for purposes of SNF consolidated billing, with respect to those services that are beyond the scope of SNF comprehensive care plans. The specific hospital outpatient services that are excluded from SNF consolidated billing are cardiac catheterization, computerized axial tomography (CAT) scans, MRIs, ambulatory surgery involving the use of an operating room, emergency room services, radiation therapy, angiography, and lymphatic and venous procedures.

! Supplies such as surgical dressings used during surgery or other treatments in the hospital outpatient setting that are also paid under the DMEPOS fee schedule. Payment for these supplies, when they are furnished in a hospital outpatient setting, is packaged into the APC payment rate

for the procedure or service with which the items are associated.

- Certain preventive services furnished to healthy persons, such as colorectal cancer screening.

Section 4523(d)(3) of the BBA 1997 amended section 1833(a)(2)(B) of the Act to provide that we discontinue reasonable cost based payment and instead make Part B payment under the hospital outpatient PPS for certain medical and other health services when they are furnished by other providers such as hospices, SNFs, and HHAs. Specifically, we proposed to pay under the hospital outpatient PPS for the following medical and other health services when they are furnished by a provider of services:

- Antigens (as defined in 1861(s)(2)(G) of the Act);
- Splints and casts (1861(s)(5) of the Act);
- Pneumococcal vaccine, influenza vaccine, hepatitis B vaccine (1861(s)(10) of the Act).

Upon implementation of the hospital outpatient PPS, we would make Part B payment for the above services under the outpatient PPS when they are furnished by an HHA or hospice program. We would also make payment for antigens and the vaccines under the PPS when they are furnished by CORFs.

(Splints and casts furnished by CORFs are paid under the rehabilitation fee schedule.) However, this provision would not apply to services furnished by a CORF that fall within the definition of CORF services at section 1861(cc)(1) of the Act. It also would not apply to services furnished by a hospice within the scope of the hospice benefit. Nor would it apply to services furnished by HHAs to individuals under an HHA plan of treatment within the scope of the home health benefit.

d. Summary of Final Action

We received no comments about the services we proposed to include within the scope of the hospital outpatient PPS. As noted in the preceding section III.B.1, we added certain implantable items to §419.2(b) to implement section 201(e) of the BBRA 1999.

3. Hospital Outpatient PPS Payment Indicators

In the September 8, 1998 proposed rule in the **Federal Register**, we proposed a payment status indicator for every code in the HCPCS to identify how the service or procedure described by the code would be paid under the hospital outpatient PPS. We received no comments on our proposal to assign a payment status indicator to every HCPCS code. (In

section III.C.6, below, we respond to commenters who disagreed with the payment status indicator that we proposed for individual codes.) Therefore, we are implementing payment status indicators as part of the hospital outpatient PPS. Addendum B displays the final payment status indicator for each HCPCS code, including codes for incidental services that are packaged into APC payment rates. Addendum E identifies the HCPCS codes to which we have assigned payment status indicator "C" to identify inpatient services that are not payable under outpatient PPS as implemented by this final rule. We respond below, in section III.C.5, to public comments about the specific codes we classified as inpatient services in the proposed rule and our final determination regarding the payment status of those codes.

The following are the payment status indicators and description of the particular services each indicator identifies:

- We use "A" to indicate services that are paid under some other method such as the DMEPOS fee schedule or the physician fee schedule.

- We use "C" to indicate inpatient services that are not paid under the outpatient PPS.
- We use "E" to indicate services for which payment is not allowed under the hospital outpatient PPS. In some instances, the service is not covered by Medicare. In other instances, Medicare does not use the code in question, but does use another code to describe the service.
- We use "F" to indicate corneal tissue acquisition costs, which are paid separately.
- We use "G" to indicate a current drug or biological for which payment is made under the transitional pass-through.
- We use "H" to indicate a device for which payment is made under the transitional pass-through.
- We use "J" to indicate a new drug or biological for which payment is made under the transitional pass-through.
- We use "N" to indicate services that are incidental, with payment packaged into another service or APC group.
- We use "P" to indicate services that are paid only in partial hospitalization programs.
- We use "S" to indicate significant procedures for which payment is allowed under the hospital outpatient PPS but to which the multiple procedure reduction does not apply.

! We use "T" to indicate surgical services for which payment is allowed under the hospital outpatient PPS. Services with this payment indicator are the only services to which the multiple procedure payment reduction applies.

! We use "V" to indicate medical visits for which payment is allowed under the hospital outpatient PPS.

! We use "X" to indicate ancillary services for which payment is allowed under the hospital outpatient PPS.

The table below lists types of services, the hospital outpatient PPS payment status indicator assigned to each type of service, and the basis for Medicare payment for the service.

Medicare Hospital Outpatient PPS Payment Status Indicators

How Medicare Pays for Various Services When They Are Billed for Hospital Outpatients

Indicator	Service	Status
A	Pulmonary Rehabilitation; Clinical Trial	Not paid
C	Inpatient Procedures	Not paid
A	Orthotics, and Non-implantable Durable Medical Equipment and Prosthetics	DMEPOS Fee Schedule

E	Nonallowed Items and Services	Not paid
A	Physical, Occupational and Speech Therapy	Rehab Fee Schedule
A	Ambulance	Reasonable cost or charge or, when implemented, Ambulance Fee Schedule
A	EPO for ESRD Patients	National Rate
A	Clinical Diagnostic Laboratory Services	Lab Fee Schedule
A	Physician Services for ESRD Patients	Bill to Carrier
A	Screening Mammography	Lower of Charge or National Rate
N	Incidental Services, Packaged into APC Rate	Packaged; No Additional Payment Allowed
P	Partial Hospitalization Services	Paid Per Diem
S	Significant Procedure, Not Reduced When Multiple Procedures Performed	Paid Under Hospital Outpatient PPS (APC Rate)

T	Significant Procedure, Multiple Procedure Reduction Applies	Paid Under Hospital Outpatient PPS (APC Rate)
V	Visit to Clinic or Emergency Department	Paid Under Hospital Outpatient PPS (APC Rate)
X	Ancillary Service	Paid Under Hospital Outpatient PPS (APC Rate)
F	Acquisition of Corneal Tissue	Paid at reasonable cost
G	Current Drug/Biological Pass-Through	Additional payment
H	Device Pass-Through	Additional payment
J	New Drug/Biological Pass-Through	Additional payment